



From Triage to Delivery Planning: Management After Massive Pulmonary Embolism

Mount
Sinai
West



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BACKGROUND

- Pulmonary Embolism (PE) is a leading cause of maternal morbidity and mortality.
- 2/2 hypercoagulability & venous stasis 2/2 pregnancy, major PE w/ RV dysfxn is an obstetric emergency and delayed treatment can be fatal.
- Systemic thrombolysis is recommended for HD unstable PE; however, use in pregnancy is rare 2/2 a lack of Rx and guidance is largely anecdotal.
- PE poses unique challenges for obstetric anesthesiologists who must rapidly coordinate care and anticipate sequelae.

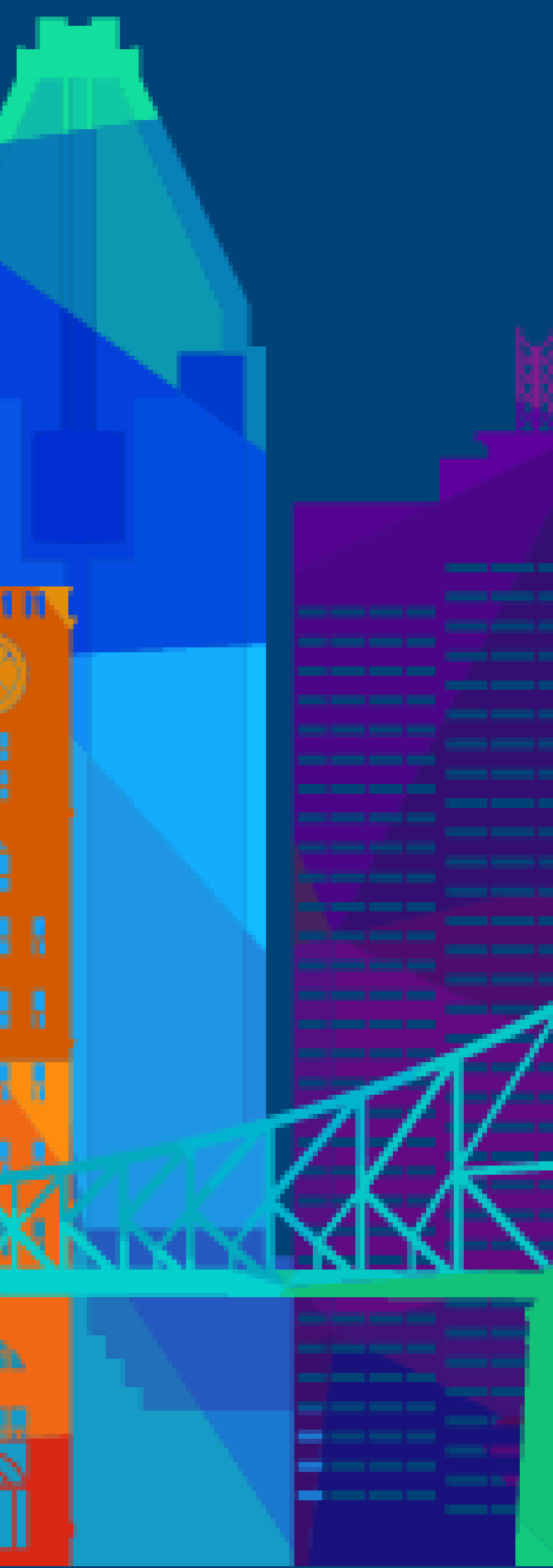




CASE DESCRIPTION



- **41-y-o G6P2123 @ 29 weeks** presents with syncope, hypotension, tachycardia, hypoxemia.
- **POC TTE: RV strain & McConnell's sign. CTA: B/L mainstem PE & RV dilation**, interventricular septal flattening.
- **½-dose systemic alteplase (50 mg) in L&D triage, f/b heparin infusion and inotropes.** Tx to 3° center for potential ECMO. Oxygenation and RV fxn improved, -> weaning of vasoactive agents and txn to therapeutic LMWH. Serial TTE: normalization of RV function and fetal status remained stable
- Subsequent normalization of coagulation: **scheduled CD under CSE** without complication.





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DISCUSSION

- This case highlights the role of obstetric anesthesiologists in the management of pregnancy-associated PE.
- POCUS was critical for rapid diagnosis and risk stratification.
- ACOG states that pregnancy is not an absolute CI to thrombolysis when a PE is life-threatening.
- Despite minimal placental transfer, alteplase carries a risk of fetal compromise indirectly through placental or uterine bleeding leading to uteroplacental hypoperfusion.

